ROUTE SLIP FOR LEGISLATIVE REPORTS

TO: Commissioner, Dr. Terry Cline T. Cline 1/12/2016

THROUGH: Director, Office of State and Federal Policy, Dr. Mark Newman MSN 1.11.16

THROUGH: Assistant Deputy Commissioner, Neil Hann 1/8/16 Ja 1-8-2015

THROUGH: Office of Scientific & Research Integrity, Pam Archer

FROM: Service Director, Annette Jacobi Connie Frederick for Annette Jacobi 1-7-16

TODAY'S DATE: 01-07-2016

TITLE OF LEGISLATIVE REPORT: Children First, Oklahoma's Nurse-Family Partnership State Fiscal Year 2015 Annual Report

DEADLINE TO SUBMIT REPORT TO DR. NEWMAN (2 weeks before final deadline below): January 1, 2016

FINAL DEADLINE FOR DISTRIBUTION TO GOVERNOR AND/OR OTHER OFFICIALS: January 15, 2016

NOTE: Please complete and attach the "Request to Distribute Programmatic Report" form.

COMMENTS:
Attached is the required annual report for the Governor, President Pro Tempore of Senate, Speaker of the House and to the chief administrative officer of each agency affected by this report.

Please contact Connie Frederick, extension 56706, for corrections, pick-up and delivery.

Request to Distribute Programmatic Report

This is a request to distribute the attached report(s) entitled:

Children First, Oklahoma's Nurse-Family Partnership State Fiscal Year 2015 Report

(NOTE: Please complete this form and deliver a hard copy along with the report and a draft of the transmittal letter to be signed by the Commissioner to Pam Archer, Director of the Office of Scientific and Research Integrity.)

Please highlight in yellow the party(ies) you wish to receive this report:

Governor, President Pro Tempore of Senate, Speaker of the House

Other Chief Administrative Officer of each Agency Affected by this Report

Is this mailing mandated by Oklahoma Statutes? (If so, please specify.)

Oklahoma Statute 63-110.1

What is the deadline for this distribution?

January 15, 2016

NOTE: 74 OS § 464 requires that these reports be transmitted electronically to the legislature.

Is this document currently on the OSDH website? No, but it will be available

URL Address (if applicable)
https://www.ok.gov/health/

Submitted by: Connie Frederick Date: 01-07-2016

Connie Frederick Program Manager FSPS
Signature Title Division

Distribution Approved:

Pam Archer — Date: 1-8-2015

Deputy Commissioner — Date

Mark S. Newman, Ph.D. — Date: 1.11.16

Terry Cline, Ph.D., Commissioner of Health — Date: 1-12-2016

Revised October 2012

Oklahoma State Department of Health
Creating a State of Health

January 7, 2016

The Honorable Mary Fallin
Governor of Oklahoma
Oklahoma State Capitol
2300 N. Lincoln Blvd., Suite 212
Oklahoma City, OK 73105

Dear Governor Fallin:

This report is provided to meet the requirements in Oklahoma Statute 63-1-110.1. *Children First* is implemented in county health departments throughout the state. In addition, the Oklahoma State Department of Health contracts with the independent Tulsa City-County Health Department and the Oklahoma City-County Health Department.

During State Fiscal Year 2015, *Children First* served a total of 2,942 families. Some of the outcomes included an increase in employment, a high rate of breastfeeding initiation and a high rate of prenatal care compliance. Although this is a high risk population, less than 1% percent of *Children First* children served in 2015 were reported to the Oklahoma Department of Human Services (OKDHS) as a potential victim of sexual abuse. Furthermore, 97% have never had a confirmed child maltreatment case with OKDHS since enrolling in *Children First*.

If you have any questions, please contact Mark Newman, Ph.D., Director of the Office of State and Federal Policy, at (405) 271-4200 or at marksn@health.ok.gov.

Sincerely,

Terry Cline, Ph.D.
Commissioner
Secretary of Health and Human Services
Oklahoma State Department of Health
1000 NE 10th Street, Suite 305
Oklahoma City, OK 73117-1299

CHILDREN FIRST

OKLAHOMA'S NURSE - FAMILY PARTNERSHIP

STATE FISCAL YEAR 2015 ANNUAL REPORT

2015

Family Support & Prevention Service
Oklahoma State Department of Health

CHILDREN FIRST

OKLAHOMA'S NURSE - FAMILY PARTNERSHIP

STATE FISCAL YEAR 2015 ANNUAL REPORT

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PROGRAM OVERVIEW

HISTORY

In 1996, the Oklahoma State Legislature authorized legislation to create Children First. Representatives from Tulsa Children's Consortium, the Oklahoma State Legislature and the Oklahoma State Department of Health reviewed home visiting models and chose to implement the "Olds Model," now known as Nurse-Family Partnership (NFP). Implementation began in SFY 1997 with pilot sites in Garfield, Garvin, Muskogee and Tulsa Counties. Current funding supports approximately 140 nurse and supervisor positions.

Oklahoma utilizes the NFP model to improve child health outcomes and minimize risk factors known to contribute to child maltreatment. The NFP model is based on more than three decades of research by David Olds, Ph.D. and colleagues. NFP has been recognized by the United States Department of Health and Human Services as an evidence-based model.[1] In addition, the model has been recognized by the Coalition for Evidence-Based Policy as meeting "top tier" evidence of effectiveness and by the Centers for Disease Control and Prevention (CDC) as a program that has great potential to reduce the economic burden of child maltreatment.[2,3] The model has been found to reduce the cost of long-term social services and to benefit multiple generations by striving to:

- Improve pregnancy outcomes by helping women alter their health-related behaviors, including reducing use of cigarettes, alcohol and illegal drugs;
- Improve child health and development by helping parents provide more responsible and competent care for their children; and
- Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.[4]

MISSION

The mission of Children First is to empower first-time eligible families to care for themselves and their babies by providing information and education, assessing health, safety and development and providing linkages to community resources, thereby promoting the well-being of families through public health nurse home visitation, ultimately benefiting multiple generations.

SERVICES

Home visitation services are provided through the county health departments under the Oklahoma State Department of Health and at the independent City-County Health Departments in Oklahoma and Tulsa Counties. Trained public health nurses provide assessments, education, information and linkages to community services to meet needs identified for each family. Nurse home visitors follow public health protocols and evidence-based NFP visit guidelines that focus on five domains of functioning: 1) personal health, 2) environmental health, 3) maternal life course development, 4) maternal role development and 5) networks for supportive relationships. Standardized assessment tools are utilized to assess risks for depression, substance abuse, intimate partner violence, physical abnormalities, child growth and developmental delays. Services rendered by the nurses are not intended to replace services provided by the Primary Care Provider (PCP). In fact, nurses often consult and collaborate with both the client's and child's PCP to ensure continuity of care and improved health outcomes. Children First services are provided to:

- Improve maternal health throughout pregnancy and after the child's birth;
- Improve child health and development from birth to age two;
- Enhance family functioning and family stability;
- Improve maternal life course development; and
- Decrease the risk of injury, abuse and neglect.

1 Avellar, S., Paulsell, D., Sama-Miller, E., and Del Grosso, P. (2013). Home Visiting Evidence of Effectiveness Review: Executive Summary. Office of Planning Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, Washington, D.C.
2 Coalition for Evidence-Based Policy. Retrieved from: http://topevidence.org/wordpress/.
3 Child Maltreatment: Prevention Strategies. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/ViolencePrevention/childmaltreatment/prevention.html.
4 Oklahoma Children First Program Evaluation Report. Nurse-Family Partnership, September 24, 2010.

SCREENING TOOLS

- Edinburgh Postnatal Depression Scale
- Health Habits Questionnaire
- Domestic Violence Questionnaire
- Ages and Stages Developmental Questionnaire
- Ages and Stages Social-Emotional Questionnaire
- DANCE (Dyadic Assessment of Naturalistic Caregiver-Child Experiences)
- Child Well-Being Scales

ASSESSMENTS

- Brief Health Assessments
- Vital Signs
- Client Weight and Blood Pressure
  - Each Pregnancy Visit
- Child Weight and Height
  - Each Visit

ENROLLMENT

Women enrolling in the Children First program must meet the following criteria:

- The participant must be a first time mother;[5]
- The monthly household income must be at or below 185% of the federal poverty level; and
- The mother must be less than 29 weeks pregnant at enrollment.

Participation in Children First is voluntary. While the NFP intervention is designed to start early in the pregnancy and continue until the child's second birthday, clients are not obligated to participate for any finite length of time.

VISIT SCHEDULE

The normal visit schedule is as follows:

- Weekly for four weeks following enrollment;
- Every other week until the baby is born;
- Every week during the six-week postpartum period;
- Every other week until the child is 21 months of age; and
- Monthly until the child turns 2 years of age.

ACCOUNTING OF ADMINISTRATIVE EXPENDITURES

The Children First program is funded primarily through state-appropriated dollars and county millage. In addition to state funding, the Oklahoma State Department of Health receives reimbursement for nursing assessments provided for clients who receive federal Medicaid benefits. Funds from the Community-Based Child Abuse Prevention grant and Maternal, Infant, and Early Childhood Home Visiting grant were also used to support the provision of direct services.

During SFY 2015, Children First operated on a total budget of $10,887,118. Using this budget, Children First served 2,942 families at a cost of $3,700.58 per family.

5 A first time mother is: 1) a woman who is expecting her first live birth, has never parented and plans on parenting this child; 2) a woman who is expecting her first live birth, has never parented and is contemplating placing the child for adoption; 3) a woman who has been pregnant, but has not delivered a child due to abortion or miscarriage; 4) a woman who is expecting her first live birth, but has parented stepchildren or younger siblings; 5) a woman who has delivered a child, but her parental rights were legally terminated within the first few months of that child's life; or 6) a woman who has delivered a child, but the child died within the first few months of life.

PARTICIPANT CHARACTERISTICS

Reports show that home visitation programs have the most benefit for young mothers with low financial, social or psychological resources.[6] In addition to these characteristics, the NFP model is designed specifically to target the young woman who is pregnant for the first time to provide the best chance of promoting positive behaviors before negative ones have taken hold.[7] Throughout the years, Children First has been successful in enrolling clients who meet these characteristics. The following demographics reflect the status of new Children First clients at enrollment during SFY 2015, unless otherwise stated.

HOUSEHOLD INCOME *Figure 1*

Children First requires participants to have a household income at or below 185% of the federal poverty level. This dollar amount varies based on the number of people in each household. For a single woman living alone, an income of $21,589 would meet the financial criteria. For a couple expecting their first baby, this amount increases to $29,100 [8] Sixty-five percent of new Children First enrollees in SFY 2015 had an annual household income of $20,000 or less.

AGE *Figure 2*

The median age of new enrollees in SFY 2015 was 21 years of age and the age range was 13 to 47 years of age. At enrollment in SFY 2015, twenty-nine percent of Children First clients were under the age of 20 and seventy-six percent were under the age of 25.

EDUCATION *Figure 3*

In SFY 2015, sixty-seven percent of new Children First enrollees had completed high school or a GED. Among mothers who had not completed high school or a GED, fifty-five percent were currently enrolled in school.

MARITAL STATUS *Figure 4*

At enrollment in SFY 2015, most (seventy-eight percent) new Children First clients were single, never married.

RACE/ETHNICITY *Figure 5*

Slightly more than half (fifty-three percent) of new Children First clients in SFY 2015 identified themselves as White. Almost half (forty-one percent) identified themselves as Hispanic, Black, or American Indian.

EMPLOYMENT *Figure 6*

Over half (fifty-two percent) of new Children First enrollees in SFY 2015 were unemployed at the time of enrollment. Twenty-three percent were employed full-time.

HOUSEHOLD COMPOSITION *Figure 7*

Just over half (fifty-one percent) of all new Children First clients lived with the father of their child in SFY 2015.

HEALTH CONCERNS *Figure 8*

Pregnancy and birth outcomes are impacted by a client's pre-pregnancy health status. Nurses utilize well-developed tools and questionnaires to assess the client's health status at enrollment. As partners, the client and nurse develop a plan of care to reduce factors associated with poor birth outcomes. The number one health concern identified at enrollment was having a high body mass index. Half (fifty percent) of new Children First clients were identified as overweight or obese (pre-pregnancy weight). Only thirty-six percent of new enrollees did not have at least one health concern at the time of enrollment in SFY 2015.

LIFE STRESSORS *Figure 9*

Assessments performed at client enrollment yield information on the types of stressors experienced by Children First clients. Questionnaires are designed to elicit information about the client's social environment, such as adequacy of housing, exposure to intimate partner violence, family stressors, incarcerations, etc. Nurses use this information to assist families in identifying areas for behavioral change and accessing needed community services.

6 Centers for Disease Control and Prevention. Task Force on Community Prevention Services. First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation. MMWR. October 3, 2003.
7 Goodman, A. Grants Results Special Report: The Story of David Olds and the Nurse Home Visiting Program. Robert Wood Johnson Foundation. July 2006.
8 2013 Poverty Guidelines. Office of the Assistant Secretary for Planning and Evaluation. United States Department of Health and Human Services. Retrieved from: http://aspe.hhs.gov/poverty/13poverty.cfm.

CHARACTERISTICS

Figure 1
HOUSEHOLD INCOME

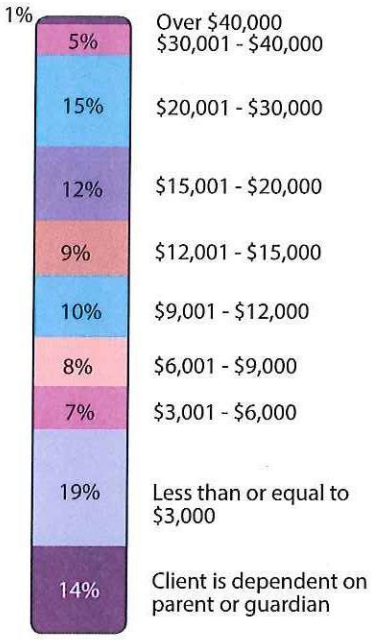


Figure 2
AGE

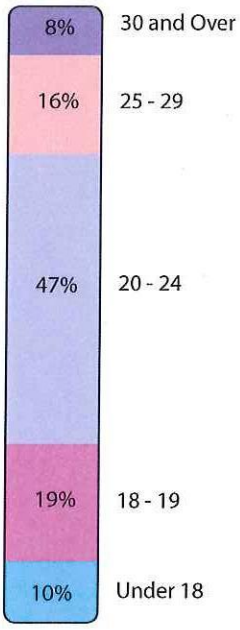


Figure 3
EDUCATION

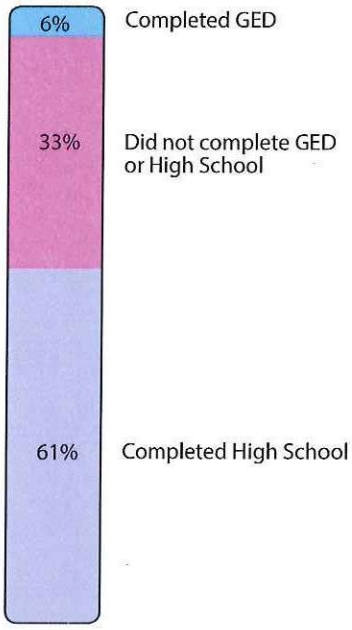


Figure 4
MARITAL STATUS

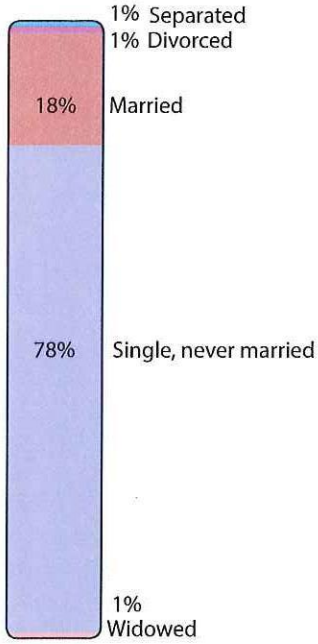


Figure 5
RACE/ETHNICITY

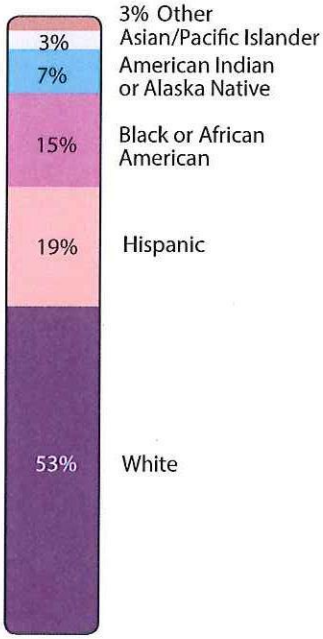


Figure 6
EMPLOYMENT

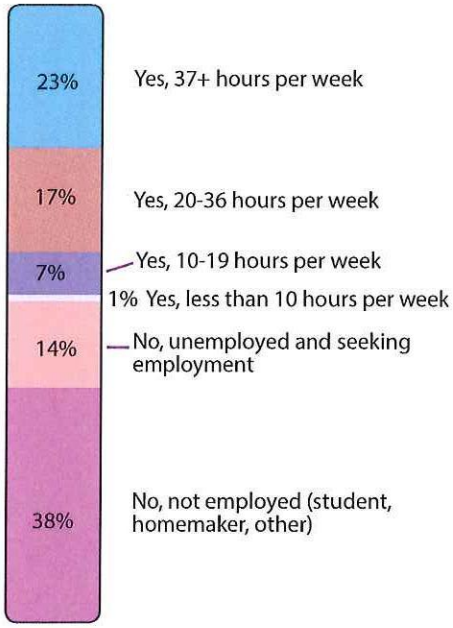


Figure 7

HOUSEHOLD COMPOSITION

Adult Type	Percent of New Enrollees
Father of the Child	51%
Other Family Members	35%
Client's Mother	28%
Husband/Partner	2%
Other Child	3%

Figure 8

HEALTH CONCERNS

Type of Concern	Percent of New Enrollees
High Body Mass Index	50%
Depression	18%
Asthma	17%
Previous Miscarriage, Fetal or Neonatal Death	8%

Figure 9

LIFE STRESSORS

Type of Stress	Percent of New Enrollees
Close family member became sick or died	33%
Client became separated or divorced	18%
Person close to the client had a problem with drinking or drugs	21%

MATERNAL HEALTH OUTCOMES

PRENATAL CARE

Beginning prenatal care in the first trimester and attending regular prenatal visits help to ensure a healthy pregnancy and increase the probability of having a healthy baby. By allowing a healthcare provider to identify potential problems early, the majority of pregnancy and birth related health issues can be prevented.[9] Children First nurses stress the importance of early and adequate prenatal care as well as connect their clients to a primary care provider. During the course of the pregnancy, the Children First nurse and primary care provider are in contact and share pertinent health information about the client to ensure continuity of care.

PRENATAL CARE

NINETY PERCENT OF CHILDREN FIRST CLIENTS WHO GAVE BIRTH IN SFY 2015 RECEIVED 10 OR MORE PRENATAL CARE VISITS.

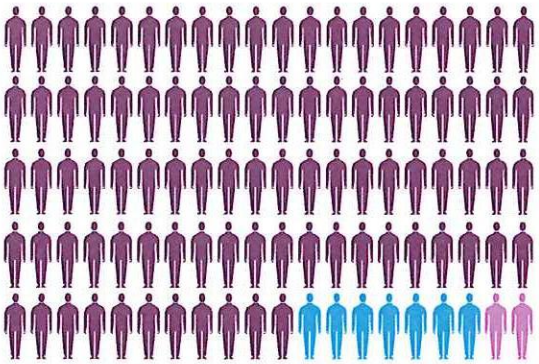
There were 3,870 Edinburgh Postnatal Depression Scale screenings administered to 1,651 mothers in SFY 2015. Approximately thirteen percent of these screenings indicated signs of depression and required immediate attention by a healthcare or mental health professional.

POSTPARTUM DEPRESSION

Postpartum depression is not preventable, but it can be treated. Nationally, approximately thirteen percent of women display symptoms of depression after the delivery of a baby.[10] Early detection of postpartum depression is a goal of Children First. Children First nurses administer the Edinburgh Postnatal Depression Scale screening at enrollment, at 36 weeks pregnancy, during the immediate postpartum period, at 4-6 months postpartum, at 12 months postpartum, and at any time that depression is suspected. Should the screening indicate signs of depression, according to the scoring tool, the Children First nurse will immediately connect the client to a healthcare or mental healthcare professional and follow up at the next visit.

SMOKING CESSATION

Smoking is one of the most important known preventable risk factors for low birth weight and preterm delivery as well as many other adverse pregnancy and birth outcomes. Additionally, exposure to secondhand smoke is a major cause of childhood disease and illness, including asthma.[11] Children First nurses utilize motivational interviewing techniques to guide behavior change and refer smokers to the Oklahoma Tobacco Helpline as well as their primary care provider to help clients decrease tobacco use.



93% percent of Children First clients served in SFY 2015 quit, reduced, or never began smoking between intake and 36 weeks of pregnancy.

Figure 10

SMOKING

- Clients who did not smoke at intake and still do not smoke (91%)
- Clients who smoked at intake and still smoke (7%)
- Clients who reduced or quit smoking by 36 weeks of pregnancy (2%)
- Clients who increased or began smoking since intake (0%)

9. Prenatal Care. Medline Plus. Retrieved from: http://www.nlm.nih.gov/medlineplus/prenatalcare.html
10. Postpartum Depression. JAMA Patient Page. Retrieved from: http://jamanetwork.com/article.aspx?articleid=186751.
11. Tobacco Use and Pregnancy. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/reproductivehealth/tobaccousepregnancy/.

CHILD HEALTH OUTCOMES

GESTATIONAL AGE AND BIRTH WEIGHT

Gestational age is the number of weeks between the date when the last normal menses began and the date of birth. Full term is defined as a pregnancy lasting 40-41 weeks. Preterm birth is the birth of an infant prior to 37 weeks gestation and very preterm defines those born prior to 32 weeks gestation. According to the CDC, preterm birth is the most frequent cause of infant death, the leading cause of long-term neurological disabilities in children, and costs the United States' healthcare system more than $26 billion each year.[12] Babies born weighing at least five pounds eight ounces (2,500 grams) are considered normal birth weight. Babies born weighing less than five pounds eight ounces are considered low birth weight, and very low birth weight infants are those weighing less than three pounds five ounces (< 1,500 grams). Babies born at low and very low birth weight are at increased risk for health problems and developmental delays.[13] Children First nurses perform a brief health assessment at every prenatal home visit. These assessments include a short health questionnaire, weight and blood pressure measurements to assess for signs and symptoms related to pre-eclampsia and gestational diabetes, and risk factors for preterm birth and/or delivery of a baby with low birth weight.

Of all Children First babies born in SFY 2015, 9% were born preterm and 2% were born very preterm. Of all Children First babies born in SFY 2015, 9% were born with low birth weight and 1% were born with very low birth weight.

NEONATAL INTENSIVE CARE UNIT

Babies born early, with low birth weight or other birth complications, may spend time in the Neonatal Intensive Care Unit (NICU). Time spent in the NICU translates into decreased attachment and bonding between mom and baby. The physical assessments conducted by Children First nurses intended to reduce the risk of preterm labor and babies born with low birth weight, also help to prevent entry into the NICU. If the baby does need to be admitted to the NICU, the Children First nurse will tailor the curriculum to help the mother care for her baby's unique needs.

In SFY 2015, 13% of Children First mothers reported that their baby spent time in the NICU.

BREASTFEEDING

Babies who are breastfed are typically healthier and have reduced risks for Sudden Infant Death Syndrome. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists promotes breastfeeding because of the benefits for both mom and baby. Children First nurses provide facts about the benefits of breastfeeding for both mom and baby as well as dispel myths. Additionally, Children First nurses demonstrate breastfeeding holds using models, and after the baby is born, can provide assistance while the mother is breastfeeding. The nurse can connect the client with a lactation consultant if necessary.

Among Children First mothers who gave birth in SFY 2015, 91% initiated breastfeeding with their new infant.

12. Preterm Birth. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm.
13. Birth Weight. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/pednss/what_is/pnss_health_indicators.htm.

CHILD HEALTH

DEVELOPMENTAL MILESTONES

The Ages and Stages developmental assessment tool is utilized to assess cognitive, language, motor, problem solving, social and emotional milestones for children enrolled in Children First. These screenings are administered to children enrolled in the program regularly, beginning when the child is two months of age. If a delay is suspected, according to the scoring tool, the nurse will refer the client to SoonerStart (early intervention), Child Guidance, or the child's primary care provider.

There were 3,567 Ages and Stages Questionnaires completed in SFY 2015 for Children First clients. In addition, 1,239 Ages and Stages – Social-Emotional Questionnaires were completed. One hundred twenty-three referrals were made to SoonerStart following a developmental screening.

At their last home visit in SFY 2015, 93% of Children First mothers reported that their child was up-to-date on their immunizations and 87% were up-to-date on their well child exams.

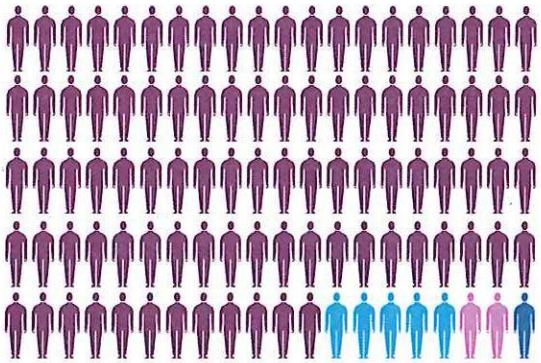
IMMUNIZATIONS AND WELL CHILD EXAMS

Children First nurses encourage and refer clients to the child's primary care provider to maintain an up-to-date status for child immunizations and well child examinations. Immunization records are retrieved from the state database and reviewed with the client. Clients can also use these records as proof of immunization when enrolling in daycare. The Children First nurse will review the assessments completed by the primary care provider during the well child visit with the client to build an understanding of their child's health.

FAMILY SAFETY OUTCOMES

INTIMATE PARTNER VIOLENCE

Intimate partner violence is a serious, preventable public health problem that affects millions of Americans. Physical, sexual, or psychological harm caused by a current or former partner not only negatively affects the physical and emotional well-being of the mother, but her children as well.[14] Children First nurses assess their clients at intake, 36 weeks of pregnancy, and when the child is 12 months of age, using a questionnaire which asks about physical, sexual, and emotional abuse. If any concerns arise, a safety plan is created by the client with the help of the nurse and a referral is made to local domestic violence services.



In SFY 2015, 97% of Children First clients did not experience domestic violence in the past six months.

Figure 11

INTIMATE PARTNER VIOLENCE

- Clients who were not experiencing domestic violence at intake and are still not experiencing domestic violence (92%)
- Clients who were experiencing domestic violence at intake, but are now not experiencing domestic violence (5%)
- Clients who were not experiencing domestic violence at intake, but are now experiencing domestic violence (2%)
- Clients who were experiencing domestic violence at intake and are still experiencing domestic violence (1%)

INJURY PREVENTION

According to the CDC, unintentional injuries such as suffocation, drowning, motor vehicle crashes, and burns are the leading causes of death and disability for children under 4 years of age.[15] Children First nurses conduct a home safety check with the family when the child is 2, 10, and 21 months of age. These safety checks include an inspection of the crib to ensure a safe sleep environment that is free from stuffed animals, bumper pads, pillows, and other people; inspection of smoke detectors, including number, placement, and working order; as well as multiple discussions about car seats, water safety, gun safety, etc.

SAFE SLEEP

Thirty-six percent of Children First clients with a child two months of age reported never co-sleeping with their child, and 31 percent reported co-sleeping with their child only some of the time in SFY 2015.

CAR SEAT SAFETY

Ninety-nine percent of Children First clients report always traveling with their child in a car seat in SFY 2015.

WATER SAFETY

Ninety-nine percent of Children First clients reported never leaving their child unattended near water in SFY 2015.

FIRE SAFETY

Ninety-one percent of Children First households had at least one working smoke detector in SFY 2015.

14. Intimate Partner Violence. Injury Prevention and Control: Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html
15. National Action Plan. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/safechild/NAP/background.html

CHILD MALTREATMENT

Of the 1,962 children who received at least one home visit from Children First in SFY 2015, 1,768 of them (90 percent) had not been named as a potential victim of an Oklahoma Department of Human Services (OKDHS) report after enrolling in Children First. Furthermore, 1,906 of them (97 percent) have not had a confirmed child maltreatment case with OKDHS after enrolling in Children First. Less than one percent (2 cases) of the Children First children served in SFY 2015 had been named in a report to OKDHS for sexual abuse. It is noteworthy that only 10 percent of the Children First families served in SFY 2015 had been reported for potential maltreatment despite all entering in the program with risk factors.

Figure 12

CHILDREN WITH A CONFIRMED CASE OF MALTREATMENT

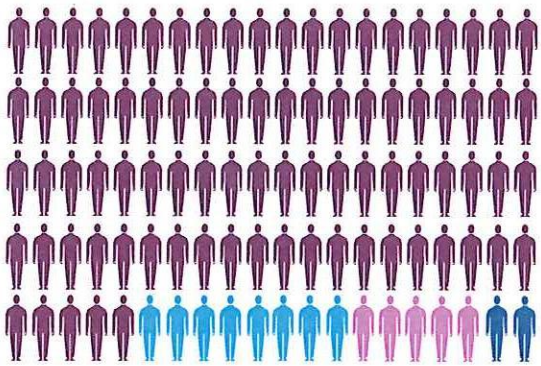
Gender	Percent
Male	60%
Female	40%
Type of Maltreatment in Confirmed Cases	
Abuse	14%
Neglect	83%
Both	3%
Type of Neglect in Confirmed Abuse Cases	
Threat of Harm	25%
Other Includes: Beating/hitting, exposure to domestic violence, failure to protect, inadequate or dangerous shelter, inadequate physical care, threat of harm, and thrown.	75%
Type of Abuse in Confirmed Neglect Cases	
Threat of Harm	16%
Other Includes: Burning/scalding, failure to obtain medical attention, failure to protect, failure to provide adequate nutrition, inadequate or dangerous shelter, inadequate physical care, lack of supervision, and thrown.	84%
Perpetrators in Confirmed Maltreatment Cases	
Mother	52%
Father	41%
Grandparent	3%
No relation	4%

Data associated with the 56 children with confirmed cases of maltreatment among the Children First children served in SFY 2015. The family may or may not have been participating in Children First at the time the report was made.

FAMILY STABILITY OUTCOMES

FATHER INVOLVEMENT

When fathers are involved in the lives of their children, the children are more likely to exhibit healthy self-esteem and do well in school.[16] Children First nurses encourage the father of the baby to participate in all home visits. If the father is unable to participate, activities are left with the mother for the father to use at a later date. The importance of the client's personal relationships is discussed, including having a supportive relationship with a person who gives mutual emotional and monetary support.



92% percent of Children First fathers spent time with their child in SFY 2015.

Figure 13

FATHER INVOLVEMENT

- Fathers who spent time with their child at intake and still spend time with their child (85%)
- Fathers who did not spend time with their child at intake and still do not spend time with their child (8%)
- Fathers who have decreased their time spent with their child since intake (5%)
- Fathers who have increased time spent with their child since intake (2%)

16. Rosenberg, J. and Wilcox, W.B. The Importance of Fathers in the Healthy Development of Children. The U.S. Department of Health and Human Services Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Chapter 3 (2006).

PREGNANCY SPACING

The amount of time between pregnancies, known as the interpregnancy interval, is calculated as the number of months between the date the last pregnancy ended and the date of the last menstrual period prior to the subsequent pregnancy. According to the CDC, women with short interpregnancy intervals may be at risk for poor pregnancy outcomes.[17] The recommended time between birth and the next pregnancy is a minimum of eighteen months.[18] Children First nurses educate their clients on the importance of family planning and refer them to their local county health department or primary care provider to receive a form of birth control.

Only eleven percent of Children First clients served in SFY 2015 were pregnant with their second child before their first child reached one year of age. By the time their first child reached 18 months of age, 25 percent of Children First mothers were pregnant with their second child.

SOCIOECONOMIC INDICATORS

Economic security is important to the well-being of children and families. Poverty places families with children at risk of experiencing unhealthy outcomes. The stress of unemployment places a burden on parents as well as financially straining the family. Parents with less education often have lower household incomes, even if they are employed full-time.[19] Children First nurses connect their clients to local services to further their education and/or obtain a job thereby increasing their income. Financial aptitude, using credit wisely, and saving are all topics that are covered during visits, including active skills building for money management.

HOUSEHOLD INCOME Of the Children First clients served in SFY 2015, 49% increased their household income by the time their child was 12 months of age.

EMPLOYMENT

Of the Children First clients served in SFY 2015 who were unemployed at intake, 61% had found work by the time their child was six months of age.

EDUCATION

Among the Children First clients over the age of 18 served in SFY 2015 who did not have a high school diploma or GED at intake, 35% earned their high school diploma or GED by the time their child was 18 months of age.

17. Interpregnancy Interval. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/pedniss/what_is/pniss_health_indicators.htm.
18. Zhu, BP. Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent U.S. Studies. International Journal of Gynecology & Obstetrics. April 2005.
19. Single-Parent Families in Poverty. Retrieved from: http://www3.uakron.edu/schulze/401/readings/singleparfam.htm.

CHILDREN FIRST ACTIVITIES

REFERRALS

Each team of nurses has developed unique strategies to reach potential clients in their respective counties. Lead nurses have provided outreach to private physicians, Indian Health Service, the Oklahoma Health Care Authority, public schools, and local community agencies. There were 4,832 referrals made to the Children First program. Of these, 4,457 met the eligibility guidelines. Among the women who were not eligible to participate, referrals were made to the Oklahoma State Department of Health Child Guidance Service and other home visitation programs such as Start Right, Oklahoma Parents as Teachers, and SafeCare.

Figure 14

PROGRAM REFERRALS

REFERRAL SOURCE	#
Women, Infants, and Children	2,255
Health Department Family Planning	1,736
Self-Referral	105
Family/Friend/Neighbor	7
Community Connector	33
Community-based Agency	5
Faith-Based Organization	23
Current/Past Children First Client	20
Health Department Maternity	16
parentPro	16
Indian Health Service	4
Hospital, Medical Provider, HMO or Private Physician	34
School	16
Department of Human Services	7
Baby Line	1
Pregnancy Testing Clinic	13
Other Home Visiting Program	15
Other	278
Unknown	248

Figure 15

SERVICES

TYPES OF REFERRALS AND SERVICES	#
Referrals	4,832
Eligible Referrals	4,457
New Enrollees	1,397
Families Served	2,942
Completed Visits	28,450
Births	833

Figure 16

2015 COUNTY DATA

County Name	Completed Visits	Referrals	Families Served	New Enrollees	Births
ADAIR	79	27	6	6	5
ALFALFA	37	25	4	3	2
ATOKA	228	8	21	6	6
BEAVER	7	25	3	3	0
BLAINE	181	52	22	11	5
BRYAN	0	113	2	2	3
CADDO	97	77	16	12	3
CANADIAN	759	57	76	50	19
CARTER	452	52	61	29	11
CHEROKEE	834	7	66	30	28
CHOCTAW	165	270	22	9	4
CIMARRON	4	31	2	1	0
CLEVELAND	3,129	246	214	80	66
COAL	93	8	10	2	2
COMANCHE	431	36	75	34	17
COTTON	39	73	8	2	1
CRAIG	385	81	27	6	9
CREEK	302	48	37	12	18
CUSTER	272	4	31	15	7
DELAWARE	440	4	34	12	16
DEWEY	0	156	0	0	1
ELLIS	39	70	3	3	2
GARFIELD	638	45	87	28	16
GARVIN	181	5	21	16	4
GRADY	203	11	24	14	7
GRANT	41	7	6	2	2
GREER	42	4	7	3	1
HARMON	22	19	2	0	1
HARPER	13	8	2	1	1
HASKELL	66	63	6	2	4
HUGHES	143	9	14	9	4
JACKSON	338	15	38	22	16
JEFFERSON	36	54	4	1	1
JOHNSTON	46	40	9	2	0
KAY	135	25	12	3	4
KINGFISHER	372	31	42	20	13
KIOWA	56	122	6	5	4
LATIMER	116	65	11	3	3
LEFLORE	648	122	73	41	13
LINCOLN	629	11	63	26	15
LOGAN	652	6	94	56	20
LOVE	65	39	10	4	2
MAJOR	31	22	4	0	0
MARSHALL	227	28	28	14	7
MAYES	59	46	9	1	1
MCCLAIN	277	40	23	11	7
MCCURTAIN	424	28	55	38	5
MCINTOSH	154	49	20	12	6
MURRAY	43	2	4	2	1
MUSKOGEE	221	25	24	16	10
NOBLE	69	684	5	0	1
OKFUSKEE	52	62	10	8	3
OKLAHOMA	4,176	5	408	153	102
OKMULGEE	314	115	36	20	12
OTTAWA	806	2	77	37	20
PAYNE	275	159	38	17	5
PITTSBURG	467	63	53	31	26
PONTOTOC	269	36	26	14	10
POTTAWATOMIE	449	144	60	28	14
PUSHMATAHA	94	17	11	6	1
ROGERS	527	103	77	46	16
SEMINOLE	236	28	28	12	5
SEQUOYAH	249	68	35	17	15
STEPHENS	61	75	12	12	2
TEXAS	114	77	22	20	7
TILLMAN	31	14	4	1	0
TULSA	5,877	635	542	254	176
WAGONER	63	10	9	9	5
WASHINGTON	257	70	26	9	11
WOODS	32	6	4	2	1
WOODWARD	181	48	21	21	8
TOTALS	**28,450**	**4,832**	**2,942**	**1,397**	**833**

CONCLUSION

SUCCESS STORY

Melissa Eagle & Family

Adair County

Melissa Eagle is a newly hired Children First home visiting nurse for Adair County. Melissa was a participant in the Children First (C1) Program 13 years ago. She was visited by 2 different home visitation nurses and the following is (in her own words) her story:

"I was a high school graduate that left home at the age of 17 and married by the age of 19. I took college courses during the day and worked at a local factory at night. At the age of 21, I was expecting my first child and had no experience of caring for a baby. Let's just say my pregnancy was off to a rough start at 7 weeks gestation. My first hospital admission was at 9 weeks resulting from hyperemesis and dehydration, which continued throughout the entire pregnancy. During a routine doctor's visit I was given information about C1, so I signed up, which was the best decision I ever made. I received a lot of information that I wasn't getting from numerous hospital stays and doctor's visits. Both nurses helped with resources I was unaware of, such as WIC, SoonerCare, etc. I was constantly encouraged through tough times (having little family support, a spouse whose job required traveling out of state, and limited income due to missing a lot of work.) They encouraged me to continue with college and later on during visits encouraged me to become a nurse. So I did! On my daughter's first birthday, I received a call that I was accepted into the LPN program on Jan 2, 2005 and completed it within 15 months. I worked as an LPN for 6 years and always thought about becoming an RN so I could work with the Children First Program. So, I applied for the RN program at Connor's State College, was accepted, completed the program and graduated. To my surprise my Children First nurse attended my graduation. I was blessed when this position opened and I applied and was selected. I started working for C1 in June 2015. I praise C1 and my nurses every day for where I am today. Because of their encouragement, I am living a dream I probably never would have pursued without their help! I have now been a nurse for 10 years, married 15 years and have 2 children ages 12 and 9."

CONCLUSION

ACKNOWLEDGMENTS

We want to thank all of the families who open their doors, their lives and their hearts to ***Children First*** home visitors. A special "thank you" to Melissa Eagle for her success story included in this year's report. In addition, we acknowledge our health department co-workers and community partners who work with us to make a difference in the lives of Oklahoma families.

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